THE JOURNAL OF SCHOOL HEALTH

Vol. XXI No. 3

MARCH
1951

Gertrude E. Cromwell, R. N.
414 14th St.
Denver 2, Colo.

PUBLISHED BY
THE AMERICAN SCHOOL HEALTH ASSOCIATION

AMERICAN SCHOOL HEALTH ASSOCIATION

Organized 1927

Devoted to the interests and advancement of those engaged in school health activities and the service rendered by them

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THE JOURNAL OF SCHOOL HEALTH

THE AMERICAN SCHOOL HEALTH ASSOCIATION

3335 Main Street, Buffalo 14, N. Y.

Published monthly, except July and August, at Buffalo, N. Y.

Editor
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Washington, D. C.

SUBSCRIPTION RATES TO THE JOURNAL

Membership dues, $3.00 including Journal: Subscription $3.00

Single copies 35c, send payment with order

Address all communications to
THE EDITOR, The Journal of School Health
3335 Main Street, Buffalo 14, N. Y.

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Entered as second-class matter at the Post Office at Buffalo, N. Y.
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A PHYSICAL EDUCATOR LOOKS AT POSTURE

KENNETH D. MILLER

Florida State University, Tallahassee, Florida

1. Introduction

The earliest interest in physical education measurement in the United States was anthropometric in nature. During the period of this emphasis the aim of the program was directed toward the development of the beautiful body, and this concept was soon recognized as being a function of poise as well as symmetry. Such an observantion led many of the physical educators of the day to a related concern over posture and body mechanics, and this interest has persisted in varying degrees to the present time.

From the beginning, however, the study of posture has advanced chiefly in the sense that it has become increasingly bewildering and inconsistent. Practitioners, both in physical education and in medicine, have contributed a mass of contradictory material pertaining to the nature of posture, until now widespread disagreement is the only consistent trend of thought on the subject among people in both fields. The purpose of this paper is to review the growth of the area of posture and body mechanics in an attempt to provide a base from which some scientist may possibly define the position and direction of this phase of the physical education program. Such a clarification seems a long overdue need.

2. Posture Theory, 1900-1930

Along with the concern over posture from an aesthetic point of view, early clinical observations indicated a close relationship between postural defects and many of the common ills of humanity. In the 1890's Mosher and other medical people were particularly engrossed with posture as an influence in the production and maintenance of deformities and displacements of the uterus,[1] and the implication of an association between posture and

1. Eliza M. Mosher, "Habits of Posture, A Cause of Deformity and Displacement of the Uterus," *New York Journal of Gynaecology and Obstetrics*, III (November, 1893), 962.

health gained further impetus during the early decades of the present century. In 1909 Seaver attributed disturbances of hepatic function, impaired digestion, constipation, and atrophy of the lumbar muscles to poor sitting posture.[2]

Sargent, in speaking of posture in 1921, expressed the general view of the period when he warned:

If there is any doubt as to the seriousness of failing to measure up to this test of young manhood, ask your physician as to the fundamental causes of the following list of physical imperfections: spinal curvature, knock knees, bow legs, flat feet, drooping head, round shoulders, weak back, varicose veins, hernia, sagging of the abdominal organs, misplacement of the pelvic organs, and many other physical weaknesses and defects which afflict mankind.[3]

Although opinions of this nature are still in evidence today, skeptics began to question such assumptions during the early twenties. Lee, for example, pointed out that poor function of the spine could either be corrected or compensated, and that it was quite possible for an individual to have very bad body mechanics without disturbances in other systems of the body.[4]

In 1926 Arnold reported that practically all instances of notable postural defects could be traced to unsound tissue rather than to poor habits of posture, and he sharply criticized the treatment of posture anomalies by physical educators.

If, then, these forms of spinal curvature are due to unsound tissue it is quite plain that preventive and medical treatment of the epiphysitis should be the mode of attack . . . Treatment by exercise during the duration of epiphysitis is absolutely contraindicated and treatment of the deformity caused by epiphysitis by exercise is absurd, a mere waste of time and effort.[5]

Schwartz, Britten, and Thompson bolstered Arnold's observations with their study of 1928. This work with a large group of men and boys indicated that little change in posture resulted from corrective exercises.[6]

---

2. Jay W. Seaver, *Anthropometry and Physical Examination*, p. 178. Meriden, Connecticut: Curtis-Way Company, 1909.

3. D. A. Sargent, "The Physical Test of a Man," *School and Society*, XIII (January 29, 1921), 128.

4. Roger I. Lee, "Some Confessions of an Internist Regarding Body Mechanics," *Journal of Bone and Joint Surgery*, V (October, 1923), 749-50.

5. E. H. Arnold, "Bad Posture or Deformity?" *American Physical Education Review*, XXXI (November, 1926), 1061.

6. Louis Schwartz, Rollo H. Britten, and Lewis R. Thompson, "Studies in Physical Development and Posture," *United States Public Health Bulletin, No.* 179, (June, 1928). Washington: United States Public Health Service. 36.

There were still two views on the effects of posture, however, and the early assumption that manifestations of structural malalignment and ptoses are casual of other disorders gradually came to include mental as well as physical ailments. Cowell expressed this extension of viewpoint when he wrote:

Physical education gives control of the will over the muscles, making possible bodily attitudes whose emotional concomitants might well be self-respect, pride, self-confidence and courage. Flabby muscles and weak will are likely to go hand in hand.[7]

During the following year Rogers criticized the work of the posture group in physical education as being "on a par with our late efforts to make everybody measure alike and weigh alike."[8] In this report Rogers supported the contention that posture is not influenced by general or specific exercises, and he warned against attempts to so modify hereditary structure.

3. Posture Theory, 1930-present

Deaver presented a study in 1933 in which he correlated posture ratings with various concepts which had been proposed as being affected by posture. The resulting coefficients indicated insignificant relationships in every instance:

Physical Fitness Index	.144
Brace Motor Ability Test	.131
Vital Capacity	.026
Intelligence	.014
Thurstone Personality Schedule	–.008
Allport Ascendancy-Submission Test	.055
Thorough Physical and Medical Examination	.123[9]

Rathbone's text of 1934 repudiated the concept of a definite standard of erectness in the antero-posterior aspect of the spine, pointing out that a considerable range of variation is entirely normal.[10] This opinion received further support from a study made by Laplace and Nicholson on 23 individuals judged to have poor postures. After a year of routine prescribed postural exercises only eight of the subjects showed any improvement in body

7. Charles C. Cowell, "Bodily Posture as a Mental Attitude," *Journal of Health and Physical Education*, I (May, 1930), 15.

8. James F. Rogers, "Corrective and Restrictive Exercises," *Research Quarterly*, II (March, 1931), 37.

9. G. G. Deaver, "Posture and Its Relation to Mental and Physical Health," *Research Quarterly*, IV (March, 1933), 227.

10. Josephine Langsworthy Rathbone, *Corrective Physical Education*, p. 101. Philadelphia: W. B. Saunders Company, 1934.

mechanics, and none of these demonstrated improvement in physiological efficiency over their first examination for the study. The authors concluded that "there are many individuals whose optimum physiologic function is attained in a posture which is not entirely correct by orthopedic standards."[11]

In his study of 1938, McCloy presented additional evidence to the notion that there is no one standard of spinal curvature to which all individuals should conform.[12] Through the use of X-rays he examined the extent to which different degrees of antero-posterior curvatures could be attributed to hereditary differences of structure of the spine and pelvis. McCloy concluded that there is a wide range of individual differences of bony structure, many of which are hereditary, and he pointed out that deviations due to bony growth asymmetries would probably be little affected by corrective exercises.

That good or poor body mechanics may have little relationship to postural habits was surprisingly revealed in evidence brought out in this study. X-rays indicated that apparently the round-backed group normally attempts to stand straighter than does the straight-backed group!

In spite of the accumulation of evidence in support of the view that posture does not depend solely upon postural habits, Thompson presented a study in 1942 in which spinal curvatures were attributed to excessive light conditions striking the peripheral retina of the eye in classroom situations.[13]

In 1945 Goldthwait and his associates offered a text based on the assumption that faulty body mechanics in early life become a vital factor in the production of a vicious cycle of chronic disease. Poor body mechanics were indicated as being a cause, directly or indirectly, of a great many human indispositions. The following list is a partial catalogue of such disorders, selected at random from this work:

Progressive paralysis, chronic arthritis, diabetes, skin lesions, cardiorenal diseases, chronic blood diseases, sciatica, lumbago, hernia, headache, neuritis, varicose veins, acute or chronic pathologic changes in gall bladder, stomach, heart, liver, or pancreas,

11. Louis B. Laplace and Jesse T. Nicholson, "Physiologic Efforts of the Correction of Faulty Posture," *Journal of the American Medical Association*, CVII (September 26, 1936), 1011.

12. C. H. McCloy, "X-ray Studies of Innate Differences in Straight and Curved Spines," *Research Quarterly*, IX (May, 1938), 50-57.

13. Charles E. Thompson, "Opthalmic Scoliosis," *Research Quarterly*, XIII (March, 1942), 68-74.

pelvic congestion, malposition of pelvic organs, dysmenorrhea, menorrhagia, irregular menstruation, indigestion, gastric or duodenal ulcers, constipation, congestions of bladder and prostate, malignant diseases, developmental deformities of head, thorax, spine, or extremities, faulty occlusion, difficulty in childbearing, bursitis, backache, displacement of the heart, heart failure, chronic cardiac disease, hypertension, hypotension, Buerger's disease, arteriosclerosis, thrombosis, secondary anemias, hyperacidity, gastric stasis, gastritis, cancer, functional disturbances of the colon, cyclic vomiting, malnutrition, increased irritability, decreased alertness, decrease in rapidity and skill with which volitional acts are performed, decreased activity of sensation, various disturbances in nervous control, chronic diseases of the nervous system, multiple sclerosis, paralysis agitans, muscular atrophy, muscular dystrophy, etc.[14]

On the other hand, Schneider and Karpovich tell us: ". . . except for the fact that lordosis may be associated with orthostatic albuminuria, there is no scientific proof that improvement in posture leads to definite improvements in the physiologic functions of the body."[15]

Such fundamental incompatibility between the viewpoints of contemporary authorities on a major issue is illustrative of the present situation of measurement in physical education. The teacher who finds such variance of opinion a commonplace occurrence in the professional literature has adequate reason to mistrust the entire program. The lack of agreement is confusing, and sound guidance is not available. Only through careful differentiation in reports between clinical observation and scientific experimentation, or between subjective opinion and factual evidence, is the judicious procedure, in terms of present knowledge, indicated. Such distinctions are seldom obvious in the brief reviews typically found in the journals of health and physical education.

4. Posture Measurement

Many of the problems arising out of the concern over posture are based on the assumption that there is accord on what constitutes "good" and "bad" body mechanics, and that accepted means of accurately measuring the range of variation between these

14. Joel E. Goldthwait, Lloyd T. Brown, Loring T. Swaim, and John G. Kuhns, *Essentials of Body Mechanics in Health and Disease.* Philadelphia: J. B. Lippincott Company, 1945. pp. xiv 337.

15. Edward C. Schneider and Peter V. Karpovich, *Physiology of Muscular Activity,* p. 286. Philadelphia: W. B. Saunders Company, 1948.

values are available. Such is not the case.

During the formative years of American physical education, while many people in the field were adding to the list of anomalies of the body due to faulty posture, there was a natural and necessary concomitant trend to attempt to measure body mechanics. The first efforts of this nature were merely tracings of spinal curvature, but in the years since many ingenious devices have evolved.

In spite of continuous attempts to accurately measure posture, however, little success has been demonstrated. In 1925 Crampton noted: "There has not been a universal agreement as to what bad posture is."[16] Two decades later only the phraseology of this statement had changed as Buhl and Morrill wrote:

The lack of a convenient and reliable means of making or recording observations has been a serious hardship . . . in the study . . . of posture.[17]

5. Summary

Thus, although orthopedists and physical educators have been working actively for the past fifty years with the problems involved in posture, there is still a seemingly unwarranted lack of agreement among practitioners of both fields. Three basic differences of opinion are implicated in this bewildering lack of unanimity: (1) whether any particular posture is more advantageous physiologically than any other posture; (2) whether prescribed physical activity can actually modify posture; and (3) whether it is possible to agree upon a definition of "good" posture and upon a method of accurately measuring such a concept. Eminent authorities in both physical education and medical circles can be found to support either side of any of these questions.

Such a predicament in no way contributes to the prestige and advancement of physical education. While the field cannot expect finality in any of its areas, reasonableness and progress are just anticipations. To date, the realization of these goals, as far as posture is concerned, has been superficial.

16. C. Ward Crampton, "Work-A-Day Tests of Good Posture," *American Physical Education Review*, XXX (November, 1925), 505.

17. Olga Anderson Buhl and Warren P. Morrill, "The Measurement of Postures," *Research Quarterly*, XII (October, 1941), 518.

CUBA'S HEALTH WORK FOR SCHOOL CHILDREN

ANNA KALET SMITH*

Prevalence of poor health among Cuba's school children caused the Government to take action after that country became independent in 1902. Physical examinations and vaccination were introduced, on a limited scope, in Habana and later in other cities. Soon afterwards a movement began for an expansion of the work throughout the country. To this end the Bureau of School Health was organized in 1935 by Dr. Aníbal Herrera y Franchi de Alfaro, who became its first director. The Bureau was placed in the Ministry of Education, because in this way it could easier obtain the school teachers' cooperation in the work.

Medical Care of School Children

The Bureau, a Government agency with public funds, began by engaging school doctors for various parts of the country. Their number was admittedly too small at first, but it increased gradually; and physical examinations were supplemented with treatment in simple cases.

At present school doctors go to the schools and examine those children who are referred to them by the teachers as appearing in need of medical attention. Special efforts are made to detect communicable diseases. In the province of Habana no treatment, except immunization, is given at the schools. The results of the examinations are reported to the parents, with a request for providing the necessary medical care.

A card record is begun for each child at the first examination and is continued throughout his school course.

Children absent from school because of illness are reported by the teacher to the school doctor, who goes to their homes and prescribes whatever treatment he can, referring serious cases to the proper agencies.

The teachers are said to report promptly suspected illnesses and actual absences, because they receive credit for the children's regular attendance.

Medical care is given to children free of charge at the school clinics, which are operating in the capitals of Cuba's six provinces. The city of Habana has two general clinics. One of them, the

* Anna Kalet Smith is specialist in foreign-language research on the staff of the Children's Bureau. The material for this article was obtained through personal interviews and observations in the course of a trip to Cuba in August-September, 1950.

Dispensario Central de Higiene Escolar, was organized in 1936 by Dr. Aníbal Herrera, who has been its director since then. In spacious and clean quarters, it is centrally located in a crowded working-class district. It is open six days a week the year round. The medical and auxiliary staff includes ten physicians, some of them specialists in diseases of the skin, eye, ear, nose and throat; four nurses, several laboratory and X-ray technicians and pharmacists.

At the clinics the children are treated for various conditions, among them intestinal parasitosis. Immunization and minor surgery, including removal of tonsils and adenoids, are performed. X-rays of the chest are taken. Cases requiring major surgery or hospitalization are sent to hospitals.

In addition to public school clinics, Cuban children are attended also in public clinics and hospitals and in those maintained by the numerous medical-care cooperative.

Dental Care

Dental care is given free to school children by dentists in the Government service. In the city of Habana dentists are employed at the seven dental clinics for school children and at the two general school clinics. In cities these dentists visit schools, examine the children, and send to the school clinics those in need of treatment. Children can also be sent to the dental clinics by the teachers.

In the clinics much stress is laid on prophylactic work. Examinations and cleanings are given twice a year. Sodium fluoride treatments, each consisting of three applications at weekly intervals, have been recently introduced. X-rays are taken; and extracting, filling, and other treatment is given.

Tooth brushes and tubes of paste are distributed to children on their first visit to the clinic; children with the cleanest mouths receive prizes, such as shoes, books, and other articles. Talks on oral hygiene are given by dentists.

In some small towns and rural districts, dentists practicing in nearby cities are employed by the Government to visit schools and treat the children. Their treatment, however, is said to be less adequate than that given in the clinics of Habana.

Mobile Health Units

Children in rural areas receive medical care at the mobile health units. Ten such units were acquired by the Government early in 1950. They are operating under the direction of Dr.

Hector Aguilera of the Ministry of Health and Social Welfare. Each unit consists of two busses and a trailer. One bus serves as a clinic and contains a small office for examining the children and preparing their individual card records; an X-ray machine with a dark room; a laboratory for examining urine, blood, and feces; a completely equipped dental chair, and a dental X-ray machine. The other bus serves as living quarters for the staff of the unit. Its six beds are used when no accommodations are available in the locality where the unit stops. This bus also has an electric stove, refrigerator, toilet, radio, and other necessities. The trailer, attached to the two busses, contains a small electric plant to produce power when the unit is stationed in areas without electricity.

The technical staff of each unit consists of a physician, who has charge of the unit, a dentist, laboratory worker, and X-ray technician. A few of the units employ a social worker, who visits the families in the locality and ascertains sanitary and other conditions as they affect children. Plans are made to employ a social worker for each unit.

A mobile health unit stays a week in each of the localities assigned to it. The present plan calls for at least one annual visit by a unit to each locality. The children attending the unit receive a general medical examination, immunization against typhoid and diphtheria, tests for tuberculosis, syphilis, and other communicable diseases, and treatment for intestinal parasitosis, which is said to affect 90 per cent of Cuba's rural population.

Dental treatment is given by dentists who travel with the unit.

It was planned originally to limit the medical and dental care to children, but it was soon found necessary to attend also the large numbers of adult patients.

Colonies for School Children

Children's colonies (colonias infantiles) are maintained for school children who are physically below par and lack proper care in their own homes. These colonies are open to boys and girls between the ages of six and 12 years, regardless of race or creed, provided they come from an indigent family and are free from a chronic disease.

The children are selected after they are examined by a school physician, and their home environment is investigated. The parents' consent is necessary for admission to a colony.

Preference is given to city children, who now make up 75

per cent of the colonies' population.

On arrival at the colony the children are vaccinated for smallpox and typhoid and examined for intestinal parasitosis. This is done by physicians who regularly visit the colonies. Treatment for intestinal parasitosis is begun without delay.

Each colony has an infirmary in a separate cottage, usually with six beds, and a nurse in attendance.

Dental care is given by visiting dentists.

During their stay at the colonies the children continue their school course. Men and women teachers live at the colonies. Classes are held outdoors, except in rainy weather.

Various forms of outdoor recreation are organized with intervals of rest periods.

At the end of a child's stay at the colony, he is again examined by a physician. Nearly all the children show an improvement. Records are kept of all cases.

The colonies, consisting of small cottages, are situated in the open country. Five such colonies are now in operation. Each serves a separate province of Cuba and accommodates more than 100 children. The colonies are open 10 to 11 months a year, except for a temporary closing when a hurricane wrecks a building.

Each colony is managed by a normal-school or university graduate, usually a man, who lives there with his family.

The colonies were given permanent standing by a law of 1934, which also assigned their general direction to the National Board of Children's Colonies. The first board was appointed soon afterward by the President of the Republic. Vacancies that have occurred since then have been filled by the board members themselves. The present membership includes physicians, teachers, lawyers, and a nurse.

The work of the colonies is supervised by a full-time medical director, who is also chairman of the board's executive council.

For the operation of the colonies the Government assigns part of the proceeds from the National Lottery. The amount, according to Dr. Carlos Hernández Miyares, medical director from the beginning, is about $225,000 annually.

"Colonia Infantil Hershey"

The colony nearest to the city of Habana is "Colonia Infantil Hershey." The colony was named after the American industrialist who leased the land and buildings for use as a colony in 1935, at a nominal charge, to the National Board of Children's Colonies. Mr. Milton Hershey had built and owned sugar mills and other

plants in that part of Cuba. The colony, 40 miles from Habana, occupies 33 acres; 14 small buildings are scattered over the rolling grounds with rich tropical vegetation.

The colony had in September, 1950, 110 boys and girls living in small, attractive cottages.

The manager of the colony is a normal-school graduate who lives there with his wife and family. The children of the colony call him uncle and his wife aunt. There are four teachers and four other assistant teachers, young men and women, also normal-school graduates.

In addition to the usual primary school course the boys are taught manual trades and vegetable gardening on a small scale; the girls sewing and cooking. No exertion is permitted to the children; all heavy work being done by regular employees.

Much time is devoted to organized games, excursions, choral singing, and motion pictures. Films, usually on cultural subjects, are sent free of charge by the American Embassy in Habana; others are bought from Metro-Goldwyn-Mayer; the latter are preferred by the children.

Since most of the children come from Catholic families, Catholic Church services are held on Sunday. Attendance is optional.

The fertile soil of "Colonia Infantil Hershey" is used for the cultivation of Indian corn, bananas, avocados, and other foods, and for dairy farming. The surplus crops are sold. With the proceeds buildings are repaired, sidewalks constructed, and other improvements made; also an auditorium was recently built where the children give theatrical performances and concerts arranged by themselves.

The children brought from the crowded city streets are at first uneasy in the new surroundings, but they soon become adjusted and enjoy themselves. At the time of the visit nearly all children looked well and happy and behaved spontaneously.

What happens to the children after they return to their squalid homes? What is awaiting those for whom there are no places in the colonies? These and related questions preoccupy Dr. Carlos Hernández and other friends of the Cuban child, in their endeavors for social betterment.

* * * * *

EVALUATING THE HEALTH WORKSHOP

DONALD BRIELAND

Institute of Child Welfare, University of Minnesota

The workshop with its emphasis on group discussion rather than on lectures has given the individual participant new freedom. We have come increasingly to recognize the value of ideas and experiences which arise from the group and may be pooled for the benefit of all. This does not mean there is no place for the expert, but that his function has changed from one of lecturer to one of resource person. We are not always aware of the responsibility which must fall on each group member in the workshop, even though it is here that success depends most upon the contributions of each participant.

If we consider the workshop from the point of view of the planning committee, there is no doubt that discussion sessions require more careful preliminary organization than do lectures. Integrating the efforts of a number of people is not always easy to accomplish, but once this is accomplished there is still another important matter to be considered, and that is evaluation. It is with methods of evaluating group participation that this discussion is concerned. The problems are much the same in a workshop as they are in a conference or in other activities where group participation is stressed. The evaluation techniques to be described here were used in a summer workshop sponsored by the Minnesota State Departments of Education and Health and attended by about forty school health directors. The main purpose of the meeting was to consider the two areas of health services and health curriculum in a five-day period. It was clear that a workshop of this length would not permit detailed discussion of two such broad subjects. However, since the group had expressed an interest in these two topics in the Spring, it was decided to consider both of them. It was hoped that this program would be a step toward the improvement of health facilities and health education in the schools concerned.

In Minnesota many of the health directors are appointed by school administrators to fulfill the provisions of state educational requirements. Some, no doubt, lack interest in their jobs. Some have limited training, and most have very little time to devote to the planning and carrying out of an adequate health program. Special attention was given in workshop planning to interest

health directors who had had very little experience so that they could get help in developing programs at their schools.

At the workshop, consultants from the two sponsoring departments and four visiting staff members served as resource persons. The major responsibility in the sessions rested, however, upon the three discussion groups which included about thirteen people each. After the first half-day session, when the groups were led by resource people, each group chose a leader from among the participants and called on the resource people for help as they saw fit. This meant that for the workshop to be a success, the various members had to contribute to the individual discussion sessions, and while the talents of the experts were used, they did not form the backbone of the workshop structure. None of the participants had had extensive group leadership training. It was felt, however, that by choosing leaders from among their own members the participants and leaders would receive more valuable experience than if resource people served as leaders.

It was decided that particular attention should be paid to methods of evaluation by the group, not only of the entire program but of the individual sessions as they went along. Those of us who were particularly interested in group dynamics were charged with the major responsibility of developing evaluation techniques.

One of the problems involved is always that of securing objective and frank criticism. Often this is difficult. For example, at the close of a recent in-service training course for teachers, the question was raised by one of the school administrators, "Would you like to have another such in-service training period?" Teachers were asked to raise their hands in answer to the question. They agreed to another series readily — much more readily, no doubt, because of the pressure that had been placed upon them in the situation. Similarly, written evaluation forms are often structured so that they do little more than to encourage general favorable statements. These may strengthen the ego of each member of the planning committee and may even convince the administrator of the success of the conference. Actually, however, when content is considered, such statements are meaningless. They only reflect the tendencies of people to be favorable because they feel they should be so. What is really important is the list of constructive suggestions.

It was the feeling of the planning committee that a running evaluation should be secured at the end of the first day of discussion on each of the two topics, services and curriculum. It was

further decided that evaluation should be made of both the accomplishment of the various groups and of the leadership that they were receiving. Two evaluation forms were prepared. The participants were instructed to turn in the one involving the group to their leader and to give the second form involving the leader to one of the resource people. Both of the evaluation forms are shown below:

EVALUATION OF GROUP PERFORMANCE

Group Number.....

Check appropriate statements and add your comments

I believe the purpose of our group is as follows:

I am ( ) clear on the purpose of our group.
am not ( )

I feel that we have overlooked some important things today

	Yes	No
(Discuss below)	( )	( )

	Yes	No
We need more of a chance to express our own ideas	( )	( )
We need help from resource people as follows:	( )	( )

We could improve our work if:

I would rate today's committee activities as

successful	( )
rather successful	( )
so-so	( )
ineffective	( )

Other comments:.....

.....

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General plan of workshop — your own comments and evaluations

Other suggestions or questions:

.....

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.....

The purpose of these running evaluation forms was to provide a quick method of learning of difficulties which might become apparent in the various sessions, and to give the leaders in their groups some idea of the progress that was being made. Thus, it would be possible for a group to change its procedure on the second day, if this seemed desirable. The completed evaluation formed the basis of discussion at a daily meeting of the resource people and the group leaders.

A final evaluation sheet was designed not only to give specific qualitative responses, but also to provide a chance for the participants to request help during the current school year. That form is summarized below:

EVALUATION OF GROUP LEADERSHIP

Group Number.....

(Circle appropriate numbers)	Fair				Excellent
1. I would describe the leadership of my group as	1	2	3	4	5
2. I feel that our progress has been	1	2	3	4	5

Suggestions:

Leader:

( ) Takes too large a part
( ) Doesn't integrate suggestions
( ) Does not use enough direction
( ) Spends too much time on small points
( ) Needs to encourage group members to talk
( ) Offers the right amount of help
( ) Needs to use resource people

Additional comments:

.....

.....

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.....

Other group members:

( ) Too few do the work
( ) Some should talk more
( ) Show enthusiasm
( ) Aren't clear on what we're doing

Additional comments:

.....

.....

.....

.....

.....

EVALUATION OF HEALTH WORKSHOP

I would rate various aspects of the workshop as follows:

	Poor		*Good*		*Excellent*
Location	1	2	3	4	5
Food Quality	1	2	3	4	5
Food Amount	1	2	3	4	5
Recreation	1	2	3	4	5
Scheduling of Meetings	1	2	3	4	5

Would you like to come back to this place in the future? Yes..... No.....

Suggestions:

Which work groups were you in? Services: 1 2 3 Curriculum: 1 2 3

Which work group was the most worthwhile for you? Services: ( ) Curriculum: ( )

Would you have preferred more:

general (full group) sessions.....
lectures .....
individual conferences .....
panel discussions .....
film showings .....

List specific criticisms of this workshop:

What help would you like next year at your school?

List topics that might be suitable for future workshops:

Additional comments:

.....

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Check the appropriate item below:

I paid my own way ( ) The school sent me at its expense ( )

Our experience indicated that these evaluation forms are readily usable. They were filled out by the workshop members in considerable detail. Criticisms were given freely but the emphasis for the most part was on means of improving the workshop rather than on negative judgments.

There is little doubt that more specific training in group techniques would have been helpful to individual members. Since this was not possible, some felt that more prepared speeches should have been included. They were impatient with the cumbersomeness of group discussion and the tendency for discussions to wander off the point. One of the things that was observed, however, was that ideas suggested tended to be unusually practical because they arose directly from the experience of the teachers concerned. It was felt that the techniques described herein provided a good index of group reaction. It is clear that the participants in any work shop should evaluate the meetings as they occur as well as at the close of the workshop. The development of evaluation methods that stress relevance, objectivity, brevity, and simplicity can contribute much to the planning of subsequent meetings.

* * * * *

Vision of Babies,—If your biology class stumps you with the question as to when babies can see, here's the answer: Vision is gradually developed the first 3 or 4 months of a normal baby's life with visual sensitivity to light present at birth, fixation acuity present a few hours later, ability to roughly follow lights developed in a few days, and some coordination of eye movement during the first week of life. Clearness of vision develops apparently the next three or four months.

Don't ask how we know what's clearly seen by a baby at 3 months! Bulletin of Health Information, Health Service Department, Denver Public Schools.

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American Council on Rheumatic Fever	Dr. Bernice Wedum (until 1952)
Pre-School Clinics and Liaison With P.T.A.	Dr. Carl Neupert

* * * * *

Diabetics,—Diabetics, with proper control, can now live their expected life span, and, in fact, with sensible precautions, may live longer with their disease than they are expected to live without it. The data from Dr. Joslin's 33,000 diabetic patients are most encouraging for control, though never cure.

It is estimated there are a million undiagnosed diabetics in the U. S., and every physician in the country should search for these among the obese (where most cases occur), among those in older age groups (where it is 50 times more common over age 65 than under age 15), and among the relatives of diabetics (where it is 7 times more frequent than among the general population). Bulletin of Health Information, Health Service Department, Denver Public Schools. J.A.M.A. June 18, 1949.

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EDITORIALS

Recently there appeared in print an item on accident prevention, especially as regards the home and the children in it.

Its thesis was based on training leading, it was hoped, to safe habits and to the avoidance of dangerous ones.

The objectives are most desirable, and the methods advocated are reasonable except for one thing. These objectives were based on discipline, of which we have "everything else but."

For years our teachers and parents have had poured upon them by and from the "educational?" psychologists the theory of self determination; the idea that the child should not be "required" to do anything, nor should he be given grades lest the lazy and mentally inadequate become "unadjusted." Is not work and applied intelligence entitled to praise and reward? As we see them in the higher grades, a large proportion of them do not do anything—and they are getting away with it.

This may work out without much repercussion in the schools and colleges where the authorities are subject to political and financial pressure, but when they get outside these areas it does not work out, either to the advantage of our youths or to that of the community in which they live.

The resulting collision between self determination of these

adult children on the one hand, and self preservation on the part of the community is juvenile—and adult—delinquency. If they want your automobile they take it; if they want your pocketbook they "mug" you to get it. These are the more serious aspects, but at a younger age—Junior and Senior High School—they often are unrestrained nuisances. They are talkers and disturbers in the motion picture houses, they jostle and "rough house" on street cars and busses; they have no concept of, and certainly do not practice, the self-restraint—the discipline—which is the real basis of courtesy, fair dealing and honesty and education in school and community.

This discipline—and certainly any effort on the part of the teacher or curriculum to build it—has been destroyed by the "educational" misnamed "psychologist" who has made such effort reprehensible.—*C.H.K.*

* * * * *

For some time it has been apparent to all except those who refuse to look that intercollegiate athletic competition is in a wretched condition. Not only is it overpublicised and therefore over-emphasized, but it has seemed in many places to be actually lacking in honesty.

Like many evils its troubles have been a gradual growth. One of the first steps down hill was in regard to scholarships. The plea of the supporters of the idea of awarding scholarships to athletes was that they should not be "discriminated against." True—they should not—but soon many were being awarded scholarships whose scholastic grades did not entitle them to such rewards. As the scholarships often did not equal the tuition, the ante was raised to tuition, soon there was included in the sums awarded such things as the cost of room, board, and books. The next step was to give all these and in addition to pay them a monthly or season, or annual cash sum. No one could disguise the fact that this was wage, or salary, for playing on the team. These players had become out and out professionals who attended classes as a side issue.

During most of this time these various payments were kept hidden. Those in charge denied their existence and ordered their employees on the team also to deny that they were receiving pay in any form.

How long did those responsible suppose these things could go on, without actually creating a dishonesty on the part of the players that was almost certain to be carried over into other

phases of life, especially as regards athletic competition. When gamblers and crooks approached these young men, they were mentally ripe for the next step, and some of them accepted bribes to try to influence the outcome of games dishonestly.

At long last the long hoped for reaction on the part of those who control the government of the universities has come. The Trustees of Long Island University, following the disclosure of the acceptance of bribes by some of the players on the University basketball team, have cancelled the rest of their basketball schedule, and banned all intercollegiate athletics. They stated—according to newspaper material in quotes: "An undue emphasis has been placed upon basketball, and perhaps on other intercollegiate sports" and that this over-emphasis "has attracted a gangster gambling element to what has appeared to them to be a lush field for further corruption inroads into the communal life of our city."

To many this will seem to be over-harsh and too vigorous action. Perhaps it is. But when the house is on fire the job of the firemen is to put out the fire.

Various intermediate steps have been proposed. To mention a few, none of which would destroy intercollegiate athletic competition:

1. Stop hiring players.
2. Forbid any athletic competition other than that held on the premises of one of the competing teams.
3. Prohibit "post-season" games.
4. Forbid long or distant trips that take players off campus for longer than three or four days at a time.

In other words—make college intercollegiate sports a college activity, for the students and by the students.—*C.H.K.*

* * * * *

ABSTRACTS AND NOTES

SCHOOL LUNCHES: THEIR NUTRITIVE VALUE AND RELATION TO THE HEALTH AND DIET OF CHILDREN*

MILLICENT L. HATHAWAY, FRIEDA L. MEYER AND SAYDE F. ADELSON

Bureau of Human Nutrition and Home Economics,
U. S. Department of Agriculture, Washington, D. C.

During the past three years the Bureau of Human Nutrition and Home Economics has participated in a number of cooperative studies involving school lunches. Some of the highlights of the results of two of these will be presented briefly.

* Condensed from the American Journal of Public Health, September, 1950, Vol. 40, Number 9, pp. 1096-1100.

Nutritive Value of the Lunches

A total of 70 meals from 15 schools were analyzed for their nutritive value. The menus used differed from day to day in different localities, but in general fitted the Standard Lunch Pattern of the National School Lunch Program.

The ascorbic acid values of the meals varied from 1 to over 100 per cent of the daily dietary allowance recommended by the National Research Council for the 10 to 12 year old child. Thirty-two of the 70 meals supplied at least 1/3 of the recommended daily allowance, and of these 29 contained citrus products.

Riboflavin did not present a problem when milk was taken as part of the meal, but the children who refused milk as a beverage received less than ⅓ of the daily allowance of this vitamin, in 60 of the 70 meals.

The Thiamine content of the meals was in general below ⅓ of the recommended day's allowance.

Food energy values for these meals ranged from 23 to 39 per cent of the daily dietary allowance, but only 8 of the 70 meals contained at least 833 calories, or ⅓ of the allowance.

None of the complete meals contained less than 20 grams of protein; 58 contained at least 23 grams, or ⅓ of the recommended allowance. If milk as a beverage was omitted, the protein in only 15 of the 70 meals contained 23 grams.

Because of the milk included, 49 of the 70 complete meals contained at least ⅓ of the recommended allowance. If milk was refused, only 1 meal met this level and only 9 meals contained ⅓ of the recommended allowance.

Pilot Study of Nutrition of Children as Affected by School Lunch

Two elementary schools in a Maryland community were selected for study, the Control School which, through lack of facilities, did not participate in the School Lunch Program in 1946-47, and the Lunch School, serving a plate lunch at noon. Each school had about 500 pupils enrolled and the economic status of the families represented was comparable. Beginning in the fall of 1947, plate lunches similar to those served in the Lunch School were also served in the Control School.

Hemoglobin determinations—Only 4 to 7 per cent of the children in these two schools had hemoglobin values below 11 grams, a level which is frequently considered to indicate marked deficiency.

Serum Ascorbic Acid—Classification according to school lunch participation reveals marked differences between groups, with a significant advantage for the children having the school lunch. There was also an apparent improvement from 1947 to 1948 in all groups. The highest percentage of children with values of 0.6 milligram, or above were found in 1948 for children who had participated in the school lunch both years. This refinement of the sample proves that the school lunch was a real factor in improving the serum ascorbic acid values of the children.

Food Consumption—The same proportion of children in each group (approximately 30 per cent) had diets that met the National Research Council's allowances in full for all dietary essentials. All of the children in the Lunch School had diets meeting at least two-thirds of allowances and only 60 per cent of those in the Control School met this level.

In the Control School the outstanding shortages in children's diets were calcium, ascorbic acid, and vitamin A. In the Lunch School calcium and ascorbic acid were also the most limiting nutrients in children's diets but to a lesser degree, especially in ascorbic acid. All children in the Lunch School had diets that met National Research Council allowances for vitamin A.. Milk and milk products other than butter, tomatoes and citrus fruit, and green and yellow vegetables, used more liberally in school lunches than in home meals, complemented the home meals with the foods that could best fill in the nutrient shortages in the children's diets.
Abstracted by H. F. Kilander, Ph.D.

* * * * *

Selective Service Rejections,—The 5.4 million 4F's of the last selective service classification were comprised in part of the following:

700,000	rejections for neuropsychiatric conditions as alcoholism, drug addiction, homosexuals.
500,000	congenital mental deficiencies, insanity, etc.
500,000	blind and deaf, or amputees.
300,000	club foot, dislocated hips, and other congenital defects.
150,000	visually handicapped.
200,000	syphilis infection.

These total to about half of the 5.4 million and may be enlightening to the critics of school health programs who infer that the best school health services and physical education should have prevented most of these rejections. Improvement should be made, of course, to help American youth attain physical and mental fitness but many of the 4F's suffered from non-preventable handi-

caps or those that cannot be corrected. Bulletin of Health Information, Health Service Department, Denver Public Schools.

* * * * *

Freak Accidents,—No man who has ever struggled into a dress shirt will be too suprprised at what happened to John H. Bradford of Richmond, Va. As director of the state budget, Mr. Bradford has pulled out of some mighty tight squeezes—but none as tight as the collar he tried to button one night in dolling himself up for an important party. Director Bradford fought so fiercely that he had to go to the hospital for emergency treatment of severe finger bruises inflicted by the collar button. He switched to sport shirts.

And, in Glendale, California, ex-City Manager Charles C. McCall has applied for state compensation with the claim that he swivelled so vigorously in his swivel chair that he hurt his back. (You lugs who don't rate swivel chairs—wipe off that smile!)

It is a well-known sociological fact that a kiss in a car has upset many a driver and many a car. But the unusual thing about the loving smack that smoocher Garrit Van Drie of Belding, Michigan, bestowed on a fair driver to cause a wreck was the fact that the recipient was his mother, and Garrit was only three.

Every year, at least one field mouse leaves the field to get in an automobile and cause an accident. This year the roving rodent hitched a ride in a car driven by Francis Jetty of St. Louis. It was discovered by Mrs. Jetty, who just did what came naturally. Her startled husband drove off the road and banged into a hydrant. Mrs. Jetty went to the doctor. The car went to the garage. The field mouse went back to the field.

The last thing in the world nine-year-old Theron Longley of Bow, N. H., expected as he wound up for a hot cadenza on his trumpet was that he would blow out four teeth. But that's what he did! Inhaling prodigiously for a final triumphant blast to a stirring march, Trumpter Theron swallowed a denture he had been wearing since an automobile accident two years before.

When officials of the Motor Vehicle Bureau suggested to Motorist Carrie Miller of Newark, Ohio, that she drop in and get her driver's license, she took them literally. Her car went out of control in front of the bureau's office, crashed through the door and injured two bureau employees. Driver test postponed! From Safety Education, February, 1951, p. 4.

* * * * *

Testing Hearing of Preschool Child,—Question: What is the best way to interest the public in the testing of preschool children?

DR. MARCUS: At the present time, there are no methods available or completely reliable for testing preschool children on a large scale. The methods presently in use make it impractical to test more than a few children at a time. I don't know what the birth rate is now, but I imagine we have something over a million and a half to two million children born a year. This would seem to make quite a problem of testing preschool children.

There is one possibility, of course, that the pediatrician can be made more interested in some kind of gross testing of hearing. For instance, there is in a new-born child a reflex, the so-called grasping reflex. When the child is dropped from a short distance his arms come up, or, if he hears a loud, frightening noise the same reflex occurs. Such a test might possibly be used by pediatricians at the initial examination.

QUESTION: Can the new type of hearing test, making use of nerve response, be used for handicapped children, that is, spastic, mentally retarded, etc. Also for preschool children?

DR. MARCUS: The test to which the question may refer has a long, medical name, psychogalvonometer response, and this has been used on small children. Using that type of test on a very young child it is hard to say how reliable a response you can get. We do feel, however, that through the use of the electro-encephalograph, we have a little bit better opportunity of telling whether any hearing is present in the very young infant.

DR. KINNEY: With reference to the question of determining how much residual hearing there may be in a young child under two years of age, I should like to say that I think all the work these men are doing is of extreme importance, but I would like to add a word of caution. If the ear doctor makes a mistake in classifying a child as having less residual hearing than eventually proves to be present, no great mistake has been made. The child deserves considerable training of all varieties, including lip reading, auditory training and the advantage of other modalities. But if the doctor should err in the other direction and say, "Oh, my tests show that your child has considerable hearing, so just forget about it," a great deal of irreparable damage has been done with respect to time lost. It has been my practice, consistently, to make the mistake, if a mistake must be made, of diagnosing a young preschool child as a great deal more deaf than he actually is. Then, if it proves to be that I am wrong, everyone is happy, and the child has not suffered one iota. If I make the mistake the other way, someone besides myself (I'm speaking of an otologist) will suffer. **From Hearing News, December, 1950, page 7.**

REVIEWS

FLOYD A. ROWE

"SHOULD JUNIOR HIGH SCHOOLS HAVE HIGHLY ORGANIZED COMPETITIVE ATHLETICS?"

Published in School Activities
November and December, 1950, p. 96.

Among the outstanding controversial problems pertinent to the organization and conduct of high school physical education that of junior high school competition is one of the most perplexing. Advocates and opponents alike distrust their own arguments. Little objective evidence is available to strengthen any case but what there is, is useful.

The problem is clear enough. Should school personnel be a party to or an opponent of the extension of vigorous competitive interscholastic sports like football and basketball into the Junior High School grades? Interscholastic competition at that level now exists. Is it good or bad? Desirable or undesirable? And for whom?

In some states the extension of sports downward has now reached the primary years. In some towns they take pride in dressing up their eight-year-olds to make like football players. One wonders how far down it will go and if there is any point to reserving tickets now for the first pre-natal home game where embryonic football players can get the full Lysenko treatment!

What are the motives for introducing these games at levels for which the games were not invented and for which the players are unprepared? Close analysis will reveal one or more of the following at work: a desire to "catch 'em young and train 'em early," i.e., develop material for the varsity faster (the junior high school becomes the "farm" club for the senior); a desire of adults to slake their undying thirst for victory, to fill the gaping voids in their own lives by vicariously participating in the victory experience; a desire of some administrations, athletic and otherwise, to enhance their reputations as organizers by getting smaller leagues together (they can smugly believe they are doing something important for youth but need never question the value of it); an honest desire to do something for younger children but without the imagination or professional competence to know what is suitable to the age, grade, or status of physiological development. These are some of the motives. There are others. Most of them are selfish, some of them are stupid, a few of them are honest, and one or two of them may be sound. At any rate, and whatever the motive, competitive athletics for children are with us and thought-

less people are vigorously promoting them as fast as the children can be changed from diapers to football pants.

If the problem is to be solved it must be looked at. The arguments and evidence for and against must be weighed. Evidence must be accumulated which will help us understand the nature of the thing we are dealing with.

There are many among medical and educational personnel near to the problem who are firmly of the opinion that the full, near-maturities of adolescence should be reached before strenuous competition should be permitted. Playing under interscholastic conditions any earlier than this may retard growth and development. Rowe supplies some argument and some evidence on this. He infers rather clearly that to ask pubescent youngsters or children to master the skills inherent in these complicated games may be asking the impossible. Such children will not have developed sufficiently to make a decent game out of it. Rowe quotes Gesell as saying that "Training somewhat hastens and perfects the manifestations of skill, but it is well to recognize that all forms of skill can rest only on a solid basis of behavior capacities which are determined by natural growth processes. The fundamental problem of educational psychology is to bring training and natural maturity into the most fruitful relations."

Rowe presents the evidence from a study made in Cleveland in which "boys competing in athletics did not gain as much in height, weight, and lung capacity as did a comparable group of boys in the same school not taking part in the competitive athletic program." And another of his studies indicates that, of three groups, boys who have a normal program of physical education in school gain in height, weight, and lung capacity over the two other groups—those who are participating in interscholastic sport and those who have no physical education in school at all. In attempting an explanation of these differences Rowe believes the psychological concomitants are the principal causes—the tensions, excitement, and demands made upon the athletes. These, he holds, may and do disturb the bodily processes sufficiently to cause observable interference with growth and development.

How definitive are the Rowe studies? They shed some light but not enough. Only a few hundred boys were used. They were conducted carefully and the evidence gathered is statistically significant but others should pick up the techniques, repeat them on thousands of boys, add new analyses, and explore other relationships. The argument against junior high school athletics suffers from an incompleteness of data relative to growth and develop-

ment. There are some people who will remain unconvinced until it can be proven that junior high school boys are *harmed* physically. If the lads are not *hurt* overtly they believe all is well. Telling the story of the possibility of injury to the epiphyseal unions* or centers of ossification is unimpressive to those who have no insight into childhood needs and developmental curves. It is hoped that studies similar to Rowe's can be extended, that physicians can assemble their experience with young athletes, and that a program of controls for junior high school athletics can be established which will save all that is good and obviate all that is bad in competitive sport. DEL OBERTEUFFER, The Ohio State University, Columbus, Ohio.

*Some of the advocates of pushing contact team games back in Junior High School grades do not know what an epiphyseal union is. They may have some vague idea that perhaps is it affiliated with the C.I.O.

* * * * *

Community Health Educators Compendium of Knowledge, Clair E. Turner, Am., Ed.M., D.Sc., Dr. P.H., C. V. Mosby Co., St. Louis, Mo. 1951. pp. 266.

This is a splendid text which meets a great need in the Health Education field. It is indeed a Compendium of Knowledge. Concise, often as listed topics in one area or procedure, it gives definite information quickly without wallowing through a trough of "pedaguise."

Divided into three major parts, each subdivided into usable units, it covers 1. Basic Principles; 2. Working With People; 3. Media of Group Communication.

This third part is particularly impressive as carrying indispensable information on methods and materials, covering the whole range from the Principles Underlying Group Communication through writing, speech, radio and television; and discussing the use of newspapers, printed matter, magazines, books, letters, motion pictures and exhibits.

The unit on Graphs and their use simplifies and makes clear one area of method that seems so terrifyingly complex that many teachers fear to use it.

The unit on Speech also is peculiarly valuable and should be taken to heart by every person who speaks to groups. All of us who attend meetings have suffered interminably and acutely from the speaker who mumbles into his shirt front — or other garments —in a deadly montone, and thus ruins what otherwise would be

an interesting and valuable presentation.

In conclusion, there is an Appendix on sources of material and an excellent bibliography reinforcing the subject matter of the text.

This book is a *must* for teachers and supervisors in this field, and for libraries in all schools and colleges where teachers are being trained.—*Charles H. Keene.*

* * * * *

A Guide to Medicine,—Ivo Geilsie-Cobb, M.D., 1951, (and others) Duell, Sloan and Pearce, New York.

This book is a God-send to the busy worker who has to use—and to understand—words and phrases of anatomy, physiology, pathology and major diseases and disorders of humans.

The arrangement—often by phases of disease or systems or organs—the desired information is easy to find.

It should be a ready reference help to nurses and medical students who are drowning in a sea of new and difficult words and phrases.—*C. H. Keene.*

Swimming and Diving; — Ambruster, David A., and Morehouse, Laurence E., C. V. Mosby Co., St. Louis, Mo. 1950, pp. 302.

This text—a second edition—is a revision of the 1942 edition (reprinted in 1946). It is excellent instructional material, organized in clear logical sequence.

Its leading chapters are devoted to Conditioning and Training. It discusses the Start, and then devotes a chapter each to the various Crawls—Sprint, Middle Distance, Distance and Back and one each to the Breast Stroke and to Relay Racing.

The balance of the material is devoted to Springboard Fundamentals, to Competitive Diving, to the conduct of competitive meets, including the duties of the different officials, and concludes with a short chapter on swimming pool construction.

Throughout, the material is concise and clear so that the coach—and even the swimmer himself—can use it profitably.

A very much worthwhile text.—*Charles H. Keene.*

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MEETINGS

American Association for Health, Physical Education and Recreation, at Detroit, Michigan, April 14 - 20, 1951.

New York State Association of School Physicians as a part of the 47th State Health Conference at Lake Placid, N. Y., June 4 - 7, 1951.